THOMAS L. GARTHWAITE, M.D.
Director and Chief Medical Officer

FRED LEAF
Chief Operating Officer

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES
313 N. Figueroa, Los Angeles, CA 90012
(213) 240-8101

September 29, 2005

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, California 90012

Dear Supervisors:

FAST TRACK ADMISSION AND VISIT POLICY
(All Districts) (3 Votes)

IT IS RECOMMENDED THAT YOUR BOARD:

Approve and instruct the Director of Health Services, or his designee, to implement a revised third party coverage Fast Track Admission and Visit Policy agreement, substantially similar to Exhibit I, to negotiate patient-specific payment rates for inpatient and/or outpatient services and enter into single-instance, per admission, or per visit agreements with third party payers, up to the lifetime maximum of the third party insurance coverage or to the date when beneficiary eligibility to insurance coverage terminates.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTIONS:

Private insurance carriers have been reluctant to enter into negotiations for coverage of their insured beneficiaries because the existing Fast Track Admission and Visit Policy (Fast Track Policy) agreement makes the payer responsible for all health care services provided at a Department of Health Services (DHS or Department) facility during an admission/outpatient visit, regardless of the patient's loss of insurance coverage. Consequently, County hospitals have lost insurance admissions and associated revenue. The proposed revision would allow the County hospitals to limit the obligation of third party payers to insurance policy limits upon request by the payer; in those cases where alternative coverage for the remainder of the services is likely to exist. It is anticipated that the revised Fast Track Policy will enable County hospitals to treat additional private payer patients and generate incremental net revenues.

FISCAL IMPACT/FINANCING:

Based on the Department's experience with the Fast Track Policy, it is anticipated that the revised agreement will increase the number of private payer patient admissions and visits to County Hospitals and generate incremental net revenues.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS:

On December 7, 1999, the Board approved the implementation of the Fast Track Policy to negotiate patient-specific payment rates for inpatient services and enter into single-instance, per-admission agreements with individuals or private payers (i.e., private Health Maintenance Organizations, Preferred Provider Organizations, and indemnity insurance plans) to admit and treat their patients at all County hospitals. A separate Fast Track contract exists for self-pay patients.

On August 13, 2002, the Board approved a revision to the Fast Track Policy to enter into similar contractual relationships for the provision of outpatient services based upon a per visit and/or a percent of charges basis. The revised Fast Track Policy also included separate forms for third party coverage and self-pay.

The current Fast Track Policy agreement language does not recognize traditional insurance policy limitations and expressly requires the payer to pay for the whole course of treatment regardless of limitations in the patient's policy. Third party benefits are normally limited to an insurance policy lifetime maximum or to the date beneficiary eligibility for insurance coverage terminates. This Fast Track Policy agreement revision allows the County to modify its usual requirement, at the request of the payer, to limit the third party payer's obligation at the point that insurance coverage ceases. It is the Department's intent that the limitation would not be granted unless the Department believes that alternative coverage exists for the remaining care. Alternative coverage means a payor who will pay inpatient payment rates which are not less than the higher of the County's inpatient Medi-Cal per diem contract rate currently in effect, or the applicable County hospital's estimated average variable cost for the applicable inpatient services. Similarly, alternative coverage includes payors whose outpatient rates are not less than the applicable County hospital's estimated average variable cost for applicable outpatient services. For patients covered by traditional fee-for-service insurance, a Medi-Cal application will be taken when indicated for the patient when services covered under a Fast Track Policy agreement are no longer eligible for insurance reimbursement. This will allow the County to collect Medi-Cal reimbursement and Disproportionate Share Hospital payments for some inpatient days not covered by insurance and additional revenue for some outpatient services.

County Counsel has approved the revised Fast Track model agreement (Exhibit I) as to form.

CONTRACTING PROCESS:

Not applicable.

IMPACT ON CURRENT SERVICES (OR PROJECTS):

It is anticipated that approval of the recommended action will increase the number of private payer patient admissions and visits to County Hospitals and increase revenue.

When approved, this Department requires three signed copies of the Board's action.

Respectfully submitted,

Thomas L. Garthwaite, M.D.
Director and Chief Medical Officer

TLG:kg

Attachments (1)

c: Chief Administrative Officer
County Counsel
Executive Officer, Board of Supervisors

FAST TRACK REVISED BOARD LETTER.wpd

County of Los Angeles - Department of Health Services
THIRD PARTY COVERAGE
AUTHORIZATION FOR PROVISION OF CARE AT COUNTY HOSPITAL
CONTRACT FOR HEALTH CARE SERVICES

(Note: All applicable blank spaces must be filled in. This form is to be signed by all parties prior to discharge from hospital for inpatient services, and prior to initiation of the course of care for outpatient services).

Patient: Social Security Number:	Address:
Payer:	Address:
Hospital:	Address:

This Contract for the provision and payment of health care services by the above named Hospital ("Hospital") is entered into by and between the County of Los Angeles ("County") and the above named Payer ("Payer") for the delivery of health care services provided by Hospital to the above named Patient ("Patient").

Payer hereby authorizes Hospital to provide [ ] inpatient and /or [ ] outpatient care to Patient for services on or about the following dates _____. Hospital agrees that it will provide, and Payer agrees that it will pay for such health care services rendered by Hospital at the negotiated payment rates listed in the attached Schedule A.

Both parties agree that County shall bill Payer at its usual and customary rates for all care including emergency medical services rendered to Patient using Form UB-92 within one year of the date of service, unless otherwise specified on Exhibit A. Payer shall pay the County at the negotiated rate(s) listed on schedule A within 45 days of receipt of the bill(s). All payments to County by Payer shall be made payable to Hospital, shall include appropriate remittance advices, and shall be sent to the address identified above.

Remuneration for services at the payment rate(s) indicated in Schedule A will be considered as payment in full. County agrees not to attempt to collect any other monies from Payer, Patient, or any other individual responsible for Patient's care, other than appropriate co-insurance or deductibles.

Both parties agree that their obligations for Patient under this contract arise at the time of admission and/or visit of Patient at Hospital and continue until such time as the treatment authorized in this document is complete. However, in the event that the Patient ceases to be an eligible member of, or covered by, Payer while still a patient at Hospital, both parties agree Payer's obligations under this Agreement will be limited to the period between the admit/outpatient service date and the date coverage ceases. However, if the rate shown on Schedule A is a flat rate per discharge then, Payer shall pay the full amount or the policy limit which ever is less.

Both parties acknowledge that County is responsible for providing care in accordance with the priorities established in the Los Angeles County Code Section 2.76.130. Accordingly, both parties agree that, should the demand for Hospital's services become such that Hospital is unable to provide continued services to Patient, County shall notify Payer and Patient in writing and Payer agrees to allow Patient's transfer to another facility as soon as reasonably possible after receipt of the notice. County will cooperate with Payer and Patient in making arrangements for the transfer of Patient to another facility. County shall not be responsible for paying for the transfer of Patient or for services or other care rendered at such other facility.

Payer agrees that County is not responsible for care rendered to Patient prior to admission and/or visit, except for emergency care provided in Hospital's emergency department immediately prior to Patient's admission.

Each party shall indemnify and hold harmless the other and its officers, employees and agents from and against any and all liability and expense, including defense costs and legal fees, for or in connection with injury or damage related to its operations or services under this Contract. The County shall be indemnified and held harmless for any Utilization Review and other decisions made by Payer that may result in a detrimental outcome to the Patient's clinical status.

Both parties agree that this Contract is made and entered into in the State of California and its provisions shall be interpreted in accordance with the laws of the State of California. Venue for any action involving this Contract shall rest exclusively in Los Angeles County.

Both parties agree to meet in good faith to resolve any disputes arising under the Contract. In the event that a dispute is not resolved, both parties agree to arbitrate such dispute. The arbitration shall be conducted pursuant to the Commercial Rules of the American Arbitration Association (AAA). Both parties agree that the arbitration results shall be binding on both parties. The cost of arbitration shall be divided equally between both parties. However, Payer shall be liable for any attorney's fees incurred by County in connection with collecting money due under this Contract.

Both parties agree that the terms of this Contract, particularly the provisions regarding compensation, are considered confidential and proprietary and shall not be disclosed except as may be required in the performance of this Contract or as otherwise required by law.

Administrator of Hospital or his or her duly authorized designee shall administer County's rights and obligations under this Contract. The undersigned individuals represent that they are fully authorized to execute this Contract on behalf of their respective parties.

In Witness whereof the undersigned, for themselves or by their duly authorized representatives have read the foregoing Contract, fully understand and agree to its terms and have caused this Contract for Health Care Services to be signed this ___ day of _____, 200__.

By Hospital Administrator or Designee;

Name _____

Title: _____

Authorized Payer Representative:

Name _____

Title: _____

Schedule A
Description of Services and Payment Methodology

Services authorized by this agreement will be billed at the following rates:
A single global rate of:
$_____ per day regardless of the medical service to which the patient is admitted (including all medically necessary inpatient, physician, routine and ancillary services, except those items and/or services expressly excluded below); or
$_____ per day regardless of the medical service to which the patient is admitted (excluding physician services, but including all medically necessary inpatient routine and ancillary services except those items and services expressly excluded below).
$_____ per case for _____ (which includes only the following items and services):
_____

OR, a rate based on the medical service in which the patient is treated (including all medically necessary routine and ancillary services, except those items and/or services expressly excluded below) at:
$_____ per day for ICU
$_____ per day for Medical/Surgical/Pediatric Acute (except ;_____)
$_____ per day for Step-down Unit
$_____ per day for Sub-Acute
$_____ per day for Rehabilitation Acute
$_____ per day for Rehabilitation Sub-Acute
$_____ per day for Skilled Nursing Facility (SNF)
$_____ for day of Surgery
$_____ for day of other (specify) _____

Unless otherwise specified such per day rates include care provided in the emergency department immediately prior to admission. For purposes of this Contract, per day rates cover all medically necessary services provided between 12:00 a.m. and 11:59 p.m., except for the following items and/or services: _____. Physician services are [ ] included or [ ] excluded and paid at a rate of _____ per day.

$_____ per visit for the following outpatient services: _____
(Description of Service)
For purposes of this agreement, a visit shall mean "an encounter with hospital personnel for the purpose of receiving diagnosis or treatment," and includes only routine services except for the following items and/or services: _____

AND/OR, at a rate based upon a percent of gross charges at:
_____% for inpatient services
_____% for day of inpatient surgery
_____% for outpatient services